

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02603

Reg. Dist. No. 233

1. PLACE OF DEATH:

County Wilcomico
 City or town Salisbury, md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
Pennamark General Hospital
 How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Wilcomico
 City or town Salisbury, md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 129 Baltimore St
 (If rural, give LOCATION) no
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Bertha Lee Holland Bell

3. (b) Social Security Number

no

4. Sex

female

5. Color or race

a a

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Charles Bell

7. Birth date of deceased (mo., day, yr.)

yes
about

6. (c) If alive, give age

Don't know
1889

8. AGE:

Years about 5-6 Months — Days — It less than one day
 hrs. min.

9. Birthplace

Palomake, md
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Same as above

MOTHER

12. Name Virginia Holland

13. Birthplace

Salisbury, md

14. Maiden name

Bertha Bell

15. Birthplace

Priggett Hill, md

16. Informant

Mr Charles Bell

Address

Salisbury, md

17. Burial, cremation, or removal. Which?

Burial Date thereof Feb 5 - 1946
(month) (day) (year)

Cemetery or crematory

Hawston

Location

Salisbury, md

18. Funeral director

James H. Stewart

Address

Salisbury, md

19. (Date rec'd by registrar)

2/5 - 1946
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 10, 1946 at Salisbury, md

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10, 1946 to Jan 31, 1946
and that I last saw him alive on Jan 31, 1946

Immediate cause of death

Pulmonary embolism

DURATION

Due to

Intestinal obstruction

Due to

Post-operative adhesions - Cecum
not due to cancer

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Physician
M. D. or other
Address..... Date signed.....

RECEIVED

FEB 16 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

 02004
 ★ Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
 County Salisbury
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 mo.
 Hospital, institution, or street address where death occurred:
105 Cherry street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
MD County Wicomico
 City or town Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2(a) If veteran, name war _____

3. (a) FULL NAME Della K. Blackstone

3. (b) Social Security Number _____

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Albert Blackstone
 7. Birth date of deceased (mo., day, yr.) March 24-1884 6. (c) If alive, give age _____ years

8. AGE: Years 61 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Wicomico Co. Md.
 (Town, county, and state)

10. Usual occupation operator

11. Industry or business Shoe factory

12. Name Albert Pursey

13. Birthplace Summit Co. Md.

14. Maiden name Nancy Ellen Sumner

15. Birthplace Wicomico Co. Md.

16. Informant Mrs. Mamie Phillips

Address P.O. Box 71, Fruitland Md.

17. Burial, cremation, or removal (Which?) Buried Date thereof Mar. 4-46
 (month) (day) (year)
 Cemetery or crematory First Am. Summit
 Location Mar. Fruitland Md.

18. Funeral director Hollway & Co. Walter R. Hollway
 Address Salisbury Md.

MEDICAL CERTIFICATION
 20. DATE OF DEATH Feb. 28th 19 46 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 46 to Feb 28 19 46
 and that I last saw her alive on Feb 21 19 46

Immediate cause of death CA of thrombosis
metastases

Duo to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)
 Major findings of operations _____
 _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where and injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE William D. Gray, M.D.
 Address Salisbury Md. Date signed 3/2/46

19. 3/4 19 46 Registrar Harriet E. Johnson
 (Date rec'd by registrar)

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MAR 12 1946

BUREAU U.S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 833

1. PLACE OF DEATH

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newly born infants give residence of mother)

State

City or town

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color of race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereon

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him or her alive on

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

MAR 12 1946

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Neocombs
City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years 6 months

Hospital, institution, or street address where death occurred:

Am. Gen. Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County NeocombsCity or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 404. Smith Street

(If rural, give LOCATION)

C13326022(a) If veteran, name war Spanish American War

3. (a) FULL NAME

Benjamin Franklin Bowler

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Nellie Bowler7. Birth date of deceased (mo., day, yr.) Aug. 16-18766. (c) If alive, give age 51 years8. AGE: Years 69 Months 5 Days 18 It less than one day hrs. min.9. Birthplace Near Richmond, Va.

(Town, county, and state)

10. Usual occupation Retired11. Industry or business Letour12. Name Benjamin F. Bowler13. Birthplace Orange Co. Va.14. Maiden name W. P. R. R.15. Birthplace W. P. R. R.16. Informant Mr. George N. BowlerAddress 404. Smith St. Salisbury Md.17. Burial (Burial, cremation, or removal, Which?) BurialDate thereof July 6th 1946Cemetery or crematorium Palmer CemeteryLocation Salisbury Maryland18. Funeral director Hollingsworth, Walter K. HollingsworthAddress Salisbury Maryland19. Date rec'd by registrar 2/6/4619. Date signed by registrar 2/5/46

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4th 1946 at 12:20 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 19, 1945 to Feb 4, 1946and that I last saw him alive on December 19, 1945Immediate cause of death PathologicDURATION 43 daysDue to Fracture of Hip (right)Accidental fall, over 60.Due to Accidental fall, over 60.Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Feb 4, 1946Where did injury occur? Near Delmar, Maryland

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At homeInjured at work? Accidental fall23. SIGNATURE Oliver T. R. R.Address Salisbury MarylandDate signed 2/5/46

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FEB 16 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 12a

CERTIFICATE OF DEATH

★ Reg. Dist. No. 333

1. PLACE OF DEATH:

Country NicaraguaCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred:

415 Davis Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County NicaraguaCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 415 Davis St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Rosie Budd

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

William Budd

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

Dec 29, 1873

8. AGE:

Years

Months

Days

If less than one day

72119hrs.min.

9. Birthplace

Delmar, Sussex, Del.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden name

unknown

15. Birthplace

16. Informant

Mrs. Marie Bradley

Address

Grand Central Annex, New York City

17. (Burial, cremation, or removal. Which?)

Date thereof

2/26/46
(month) (day) (year)

Cemetery or crematory

Kalsho Hill Cemetery

Location

near Delmar, Del.

18. Funeral director

David H. Messick

Address

Hebron Md.

19. (Date rec'd by registrar)

2/29/462/29/46Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17th 1946 at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Medical Examiner's Report to 19 and that I last saw alive on 19

Immediate cause of death

Cerebral Hemorrhage

DURATION

sudden

Due to

Aortic sclerosis8 yrs

Due to

arteriosclerosis of heart3 weeks

Other conditions

arteriosclerosis of heart

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 1/30/46Where did injury occur? Salisbury, Maryland
(City or town) (County) (State)Injured at home, farm, industry, public place (where)? HomeMeans of injury fallInjured at work? no

23. SIGNATURE

Oliver Fisher

M. D. or other

Address Salisbury, Md. Date signed 2/27/46

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MAR 12 1946

BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-1)

CERTIFICATE OF DEATH

Reg. Dist. No.

H336

1. PLACE OF DEATH:

County Wicomico
 City or town Delmar and side
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? about 67 years
 Hospital, institution, or street address where death occurred: na
 How long in hospital or institution? na

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico
 City or town Delmar and
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. na
 (If rural, give LOCATION)
 2.(a) If veteran, name war na

3. (a) FULL NAME

Gertrude Harriet Burns

3. (b) Social Security Number

na

4. Sex female 5. Color or race A-A 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Wigle Burns
 6.(c) If alive, give age na years
 7. Birth date of deceased (mo., day, yr.) 18-80

8. AGE: Years about 65 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Quantico md
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business same as above

12. Name Calvinus Crawford

13. Birthplace Quantico md

14. Maiden name Kitty Day

15. Birthplace Quantico

16. Informant Mrs. Leland Hallaway

Address Delmar md

17. Burial Date thereof Feb. 13, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Union

Location Delmar

18. Funeral director James O. Stewart

Address Salisbury md

19. Feb. 15, 1946 Harry F. Hudson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1946 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6, 1945 to Feb. 11, 1946
 and that I last saw h. er alive on Feb. 1, 1946

Immediate cause of death Chronic Myocarditis DURATION 2 years

Due to (Acute attack)

Due to Hypertension 8 years

Other conditions na

(Include pregnancy within 3 months of death)

Major findings of operations na Date of op. na

Autopsy results na

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide na Date of na

Where did injury occur? na (City or town) na (County) na (State)

Injured at home, farm, industry, public place (where?) na

Means of injury na Injured at work? na

23. SIGNATURE G. Herbert Sewby M.D. M. D. or other na

Address Salisbury md Date signed 2/24/46

RECEIVED
FEB 19 1946
BUREAU V R

Evidence for the addition of
MARITAL STATUS and M. O. B. NAME
Show only
Robert H. Corbin
M No. G 110 JUL 17 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

Reg. Dist. No. 033

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days - 14 hrs - 35 min.
Hospital, institution, or street address where death occurred:
F. B. Hospital
How long in hospital or institution? 3 days 14 hrs - 35 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wor
City or town Snow Hill Rural 2
(If outside city or town limits, write RURAL and give nearest town)
Street No. 111
(If rural, give LOCATION)
2. (a) If veteran, name war World War I IV

3. (a) FULL NAME

Corbin Robert Henry

3. (b) Social Security Number

157-18-7440

4. Sex M 5. Color or race Col 6. (a) Single, married, widowed, or divorced Single married

6. (b) Name of husband or wife Ruth M. Tull

7. Birth date of deceased (mo., day, yr.) April 23 - 1901 8. (c) If alive, give age 46 years

8. AGE: Years 44 Months 9 Days 16 If less than one day hrs. min.

9. Birthplace Snow Hill, Worcester, Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

12. Name John Corbin

13. Birthplace Maryland

14. Maiden name Elizabeth Corbin

15. Birthplace Maryland

16. Informant Mrs. Hattie Snoddy

Address Snow Hill, Md Rural 2

17. (Burial, cremation, or removal, which?) Burial Date thereat Feb 17 1946
(month) (day) (year)

Cemetery or crematorium First Baptist Church

Location Snow Hill, Md

18. Funeral director Heame & Dunning

Address Snow Hill, Md

19. 2/13/46 19 46 Married E. Johnson
(Date rec'd by registrar) (year) (month) (day) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 19 46 at 7:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5 19 46 to Feb 9 19 46 and that I last saw him alive on Feb. 9 19 46

Immediate cause of death Pneumonia DURATION 24 hours

Due to Acute Myocardial Failure 2 days

Due to Chronic Pancreatitis

Other conditions with Massive Hypertrophy, (?)

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. as above

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of Feb 9 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury St. Rivers Hanson, M. D. Injured at work?

23. SIGNATURE St. Rivers Hanson, M. D. M. D. or other

Address Salisbury, Md Date signed 2/10/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 9 1946

BUREAU

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

CERTIFICATE OF DEATH

02010
Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? one week
 Hospital, institution, or street address where death occurred: na
 How long in hospital or institution? na

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico
 City or town Salisbury md
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 612 Delaware St
 (If rural, give LOCATION)
 2.(a) If veteran, name war na

3. (a) FULL NAME

Bessie E. Davis

3. (b) Social Security Number

lost

4. Sex

female

5. Color or race

a.a.

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Israel Davisyes6. (c) If alive, give age 5-5 years

7. Birth date of

deceased (mo., day, yr)

June 8 1893

8. AGE:

Years

Months

Days

If less than one day

5-3

hrs. min.

9. Birthplace

Allen md

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Same as above

FATHER

12. Name

James A. Dutton

13. Birthplace

Maryland

MOTHER

14. Maiden name

Phyllatt Byrd

15. Birthplace

Quantico md

16. Informant

Israel Davis

Address

Salisbury md

17. Burial

Burial

Date thereof

March 3 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Friendship

Location

Salisbury md

18. Funeral director

James A. Stewart

Address

Salisbury md

19. Date

3/3/46

Date signed by registrar

3/3/46

20. Signature

Bessie E. Davis

21. Signature

Israel Davis

22. Signature

James A. Stewart

23. Signature

James A. Stewart

24. Signature

James A. Stewart

MEDICAL CERTIFICATION

20. DATE OF DEATH

2-261946 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-301946to 2-241946

and that I last saw him

alive on2-241946

Immediate cause of death

Apoplexy

DURATION

7 days

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

E.A. Purnell, M.D.

M. D. or other

Address

300 W. Main StreetDate signed 2-28-46

RECEIVED

MAR 12 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Lawry

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

CERTIFICATE OF DEATH

02011

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury Md. Route #4
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Lifetime
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Salisbury Route #4
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Salisbury Md. Route #4
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Alice Pryor Dixon

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife John M. Dixon

6. (c) If alive, give age deceased years

7. Birth date of deceased (mo., day, yr.) May 23, 1878

8. AGE: Years 67 Months 9 Days 4 It less than one day hrs. min.

9. Birthplace near Salisbury Md. Wicomico (Town, county, and state)

10. Usual occupation House work

11. Industry or business at home

12. Name David Pryor

13. Birthplace Edgar Md. Wicomico

14. Maiden name Charlotte Owens

15. Birthplace Worcester County

16. Informant Mr. Roland Dixon

Address Salisbury Md. Route #4

17. Burial (Burial, cremation, or removal, Which?) Date thereof Mar 1, 1946 (month) (day) (year)

Cemetery or crematory Wicomico Memorial Park

Location Salisbury Md.

18. Funeral director

Address Salisbury Md.

19. 3/1/46 (Date read by Registrar)

19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 19 46 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 2-27-46

Immediate cause of death

Anemia Sec. Cause?

Due to

prob due to

Due to Bleeding from her nose 4 days

Removal of

Other conditions not due to tuberculosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide or homicide Date of

Where and how occurred? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address Date signed 3/1/46

RECEIVED

MAR 12 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02012

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Thionio
 City or town Schickau
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 year 6 months
 Hospital, institution, or street address where death occurred:
Rural
 How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Thionio
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. ✓
 (If rural, give LOCATION)
 2.(a) If veteran, name war World War I

3. (a) FULL NAME

Dulaney, W. Earle

3. (b) Social Security Number

✓

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

B. (c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.)

July 6, 1888

8. AGE:

Years

Months

Days

If less than one day

57714hrs.min.

9. Birthplace

Parkley, Accomac, Va.
(If give county, and state)

10. Usual occupation

Auto

11. Industry or business

FATHER

12. Name

Harry S. Dulaney

13. Birthplace

Thionio, Md.

MOTHER

14. Maiden name

Edwina Phillips

15. Birthplace

Thionio, Md.

16. Informant

Harry S. Dulaney

Address

Frederick, Md.

17. (Burial, cremation, or removal. Which?)

Cremation

Date thereof

7/34/46

Cemetery or crematory

Ant Lincoln

Location

Baldwin Blvd. Hagerstown, Md.

18. Funeral director

Reid & Johnson Co.

Address

Schickau, Md.

19.

2/23/4619462/23/462/23/462/23/462/23/46

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 2019 46 at unknown

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

medical attention 19 46 to death 19 46and that I last saw him alive on 2/23/46 19 46

Immediate cause of death

Barbiturate poisoning

DURATION

unknown

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

none

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

suicideDate of 2/15/46

Where did injury occur?

shed front business md

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

woods lot

Manner of injury

self-administered

Injured at work?

no

23. SIGNATURE

Dr. Rademaker M.D.
Deputy Medical Examiner
M. D. or other

Address

Delaware, Md.Date signed 2/23/46

RECEIVED

MAR 12 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

CERTIFICATE OF DEATH

02013

Reg. Dist. No. 333

1. PLACE OF DEATH:

County... Wicomico
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 years
 Hospital, institution, or street address where death occurred:
Blake St Salisbury, Md
 How long in hospital or institution? 4

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Virginia County...
 City or town... Norfolk
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 906 Paulkland St
 (If rural, give LOCATION)
 2. (a) If veteran, name war... no

3. (a) FULL NAME

Al Pillas

3. (b) Social Security Number

no

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male aa single

6. (b) Name of husband or wife about 18977. Birth date of deceased (mo., day, yr.) about 48 yrs 1898

8. AGE: Years Months Days If less than one day
about 48 hrs. min.

9. Birthplace Philadelphia Penn.
(Town, county, and state)10. Usual occupation Laborer11. Industry or business Same12. Name James Williams13. Birthplace Phila. Penn14. Maiden name Margaret Chatham15. Birthplace Plymouth N. C.16. Informant Mrs. Katie AustinAddress 906 Folkin St, Norfolk Virginia17. Burial Date thereof 12-26-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Stonewall CemeteryLocation Salisbury Maryland18. Funeral director James H. StewartAddress 402 E. Church St. Salisbury Md19. 2/26/46 19. 46 Harriet S. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1946 at 5 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-3 19. 46, to 1-18 19. 46and that I last saw him alive on 1-18 19. 46Immediate cause of death InanitionDue to InanitionDue to Pulmonary Tuberculosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. M. D.Address W. M. D.Date signed 2-26-46

RECEIVED
MAR 12 1946
BUREAU 3

Dr. Rademacher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH



Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

57 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wor.City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)Street No. 1
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Fisher Mr. Edward T.

3.(b) Social Security Number

4. Sex

Male

5. Color or race

W

6.(a) Single, married, widowed, or divorced

✓

8.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

42110

hrs.

min.

9. Birthplace

Berlin, Worcester, Md.
(Town, county, and state)

10. Usual occupation

Carpenter

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. 3/2/46

19. 46

Date rec'd by registrar

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 2/26 19 46 at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1 19 46 to 2/26 19 46and that I last saw him alive on 2-26 19 46

Immediate cause of death

Familial splenomegaly
anemia

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Enlarged spleenDate of op. 1/2/46Autopsy results Enlarged spleen & liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 26

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

RademacherM.D.

M. D. or other

Address Salisbury Md Date signed 3/28/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 15702

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County HarfordCity or town White Haven
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....
Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HarfordCity or town.....
(If outside city or town limits, write RURAL and give nearest town)Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Bottles, Baby

3. (b) Social Security Number

4. Sex

male

5. Color or race

col.

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

3

hrs.

min.

9. Birthplace

White Haven Md
(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory.....

Location.....

16. Funeral director

Address

19.

(Date rec'd by registrar)

19.

1986

R. Woodford Gattis
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 10 1986, at..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....
and that I last saw him alive on..... 19.....

Immediate cause of death

new born -
congenital hypoplasia

DURATION

3 hrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Salisbury Md Date signed 2/10/86

RECEIVED
MAR 6 1946
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02016

Reg. Dist. No. 331

1. PLACE OF DEATH:

County Wicomico
 City or town Salisbury, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
at home
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md County Wicomico
 City or town Spring Hill
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Salisbury Rural 2
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Franklin Grant Loslee

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Eda May Loslee

7. Birth date of deceased (mo., day, yr.)

April 12 1861

8. AGE: Years Months Days if less than one day

80 10 5 hrs. min.

9. Birthplace

Spring Hill, Md

10. Usual occupation

Lumber

11. Industry or business

12. Name

John Selby Loslee

13. Birthplace

Wicomico Co., Md

14. Maiden name

Anna Maria Bethune

15. Birthplace

Salisbury, Md

16. Informant

Mrs. Earl T. Hargens

Address

Salisbury, Md Rural 2

17. Burial

Date thereof 2/21/46

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Spring Hill, Md

Location

The Hill & Johnson Co

18. Funeral director

Address

Salisbury, Md

19. March 9 1946

Miss J. M. Wallace

Registrar

Address

Salisbury, Md

Date signed

Feb 17 1946

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 17 1946 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 8 1846 to Feb 17 1946

and that I last saw him alive on Feb 16 1946

Immediate cause of death Acute cardiac

failure

DURATION

Due to Chronic myocarditis 2 yrs

Due to Chronic nephritis 3 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Lynch

M. D. or other

Address

Salisbury, Md

Date signed

Feb 17 1946

RECEIVED

MAR 13 1946

BUREAU U. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No.

537

1. PLACE OF DEATH:

County.....WicomicoCity or town.....Wetipquin Quantico I
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....60 Years

Hospital, institution, or street address where death occurred:

At Home

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md County.....WicomicoCity or town.....Wetipquin
(If outside city or town limits, write RURAL and give nearest town)Street No.....Quantico I
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

Phoebe J. Hambury

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widowed6.(b) Name of husband or wife.....Julius F. Hambury

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

March, 14, 1862

8. AGE:

Years

Months

Days

If less than one day

831026

hrs.

min.

9. Birthplace.....Dorchester, Co. Md
(Town, county, and state)10. Usual occupation.....At Home

11. Industry or business

FATHER

12. Name.....George Wingate13. Birthplace.....Dorchester, Co. Md

MOTHER

14. Maiden name.....Virginia Flower15. Birthplace.....Dorchester, Co. Md16. Informant.....Mr. Howard HamburyAddress.....Wetipquin, Md17. Burial Date thereof.....2 / 11 / 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....Wetipquin Church CemeteryLocation.....Wetipquin, Md18. Funeral director.....The Hill & Johnson Co.Address.....Salisbury, Md19. Feb 11 19 46 R. W. Walpole Walter
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Feb. 9 1946 at 7:55 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 1 1946 to Feb 9 1946
and that I last saw him live on Feb 7 1946

Immediate cause of death.....

Cerebral hemorrhage

DURATION

6 days

Due to.....

Due to Chronic valvular heart dis

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work?

23. SIGNATURE.....

W. W. Walpole M.D.

M. D. or other

Address.....Salisbury Md Date signed Feb 10 46

RECEIVED

MAR 6 1946

BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 732

CERTIFICATE OF DEATH

Reg. Dist. No. 333

I. PLACE OF DEATH:

County... Wicomico
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 50 Years
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution? 3 Weeks & 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md County... Wicomico
 City or town... Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 Street No... 215 Hazel Ave
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mary L. Harris

3. (b) Social Security Number

4. Sex FEMALE 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed
 6.(b) Name of husband or wife I. James Harris
 6.(c) If alive, give age..... years
 7. Birth date of deceased (mo., day, yr.) Dec. 13, 1872
 8. AGE: Years 73 Months 2 Days 11 If less than one day
hrs.min.

9. Birthplace... Wicomico, Co. Md
 (Town, county, and state)
 10. Usual occupation... At Home
 11. Industry or business

12. Name Azariah C. Bounds
 13. Birthplace Wicomico, Co. Md
 14. Maiden name Mary A. White
 15. Birthplace Wicomico, Co. Md

16. Informant Mr Morris Bounds
 Address Salisbury, Md
 17. Burial Date thereof 2/26/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Parsons Cemetery
 Location Salisbury, Md
 18. Funeral director The Hill & Johnson Co.
 Address Salisbury, Md

19. 2/26/46 19. 46
 (Date rec'd by registrar) Registrar Reggie E. Johnson

MEDICAL CERTIFICATION

2D. DATE OF DEATH... Feb. 24 1946, at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
1943 19..... to Feb 24 19.....
 and that I last saw her alive on Feb 23 19.....

Immediate cause of death... thrombocardiitis
 DURATION 3 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE W. H. D.
 M. D. or other

Address Salisbury Date signed Feb 24

RECEIVED
MAR 12 1946
BUFFALO, N. Y.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 772

CERTIFICATE OF DEATH

02019

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Near Millards Md
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____

City or town _____
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Bremer Herrick

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Divorced

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) Aug 10 1887
6. (c) If alive, give age _____ years8. AGE: Years Months Days If less than one day
58 4 23 _____ hrs. _____ min.9. Birthplace Near Middleton Del
(Town, county, and state)10. Usual occupation laborer

11. Industry or business

12. Name Albert Herrick13. Birthplace Odessa Del14. Maiden name Martha Appleton15. Birthplace Odessa Del16. Informant George VandegriftAddress Wilmington Del17. Burial Date thereof Feb 26 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bethel CemeteryLocation Near Millards Md18. Funeral director Wm Howard WellsAddress Pittsville Md19. 3/25/46 Married John Shelton
(Date rec'd by registrar) (year) (month) (day) (name) (name)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 1946 at 5:30 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 1946 to Feb 23 1946 and that I last saw him alive on _____ 19____
Medical Examiner's CertificateImmediate cause of death Acute Alcoholism renal
_____ failure

Due to _____

Due to _____

Other conditions Chronic Alcoholism renal
failure

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Charles Fischer md
_____ M. D. or other _____Address _____ Date signed 25-46

RECEIVED
MAR 12 1945
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1830

CERTIFICATE OF DEATH

Reg. Dist. No. 330

1. PLACE OF DEATH: Thiemois
 County.....
 City or town.....Mardela Md R.D.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....30 years
 Hospital, institution, or street address where death occurred:

 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....MD County.....Thiemois
 City or town.....Mardela Md. R.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME.....George H. Higgins

3. (b) Social Security Number

4. Sex.....M 5. Color or race.....white 6. (a) Single, married, widowed, or divorced.....married

6. (b) Name of husband or wife.....Fannie S. Higgins

7. Birth date of deceased (mo., day, yr.).....Oct 13 1875 6. (c) If alive, give age.....70 1/2 years

8. AGE: Years.....70 Months.....4 Days.....6 It less than one day.....hrs.min.

9. Birthplace.....Riverton Thiemois Md
 (Town, county, and state)

10. Usual occupation.....Retired / Day Captain

11. Industry or business.....

12. Name.....John Robert Higgins

13. Birthplace.....Md

14. Maiden name.....Elvora Walker

15. Birthplace.....Md

16. Informant.....Fannie S. Higgins

Address.....Mardela Md R.D.

17. Burial.....Burial Date thereof.....2-23-1946
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory.....Riverton

Location.....Riverton Md

18. Funeral director.....Gravenor Bros

Address.....Shapstown

19. 2/23/46 19.....2/23/46
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Feb 19 1946 at 10:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....1927 to.....Feb 19 1946
 and that I last saw him alive on.....Feb 19 1946

Immediate cause of death.....Cerebral Hemorrhage DURATION.....199 yrs

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....H. O. Tahlman M. D. or other.....2/21/46

Address.....Shapstown Md Date signed.....

RECEIVED
MAR 4 1946
BUREAU V.M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85

02021

Evidence for addition of age

of deceased is shown on

FILM No. 104 MAY 28 1946

CERTIFICATE OF DEATH

Reg. Dist. No. H336

1. PLACE OF DEATH:

County Wicomico
 City or town Delmar
 (If outside city or town limits, write RURAL NEAR and give town)
 Street address, hospital, or institution: 8 W. Elizabeth St.
 Stay in hospital or inst. (yrs., or mos., or days) _____
 Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Wicomico
 City or town Delmar Ward No. _____
 (If outside city or town limits, write RURAL NEAR and give town)
 Street No. 8 W. Elizabeth St.
 (If rural, give LOCATION)
 2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Elizabeth Senestere Hitchens

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) July 12 - 1944

8. AGE: Years 1 Months 6 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Delmar, Ind.
 (Town, county, and state)

10. Usual occupation _____

11. Industry or business _____

FATHER 12. Name Dallas Hitchens

13. Birthplace Delmar, Del.

MOTHER 14. Maiden name Francis Bramble

15. Birthplace Worcester County, Md.

16. Informant Dallas Hitchens

Address Delmar, Del.

17. Burial Date thereof Feb - 6 - 1946
 (Burial, cremation, or removal, whichever) (month) (day) (year)

Cemetery or crematory G. E.

Location Delmar, Del.

18. Funeral director W. S. Marshall & Co.

Address Delmar, Delaware

February 5, 1946 Harry E. Hudson
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 4 1946, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to Feb. 4 1946,

and that I last saw her alive on February 3 1946.

Immediate cause of death Status epilepticus DURATION 2 days

Due to Epilepsy 1 year

Due to Previous meningitis

Other conditions none

Major findings: _____

Of operations _____

Of autopsies _____

(Include pregnancy within 3 months of death)

Physician: _____

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State) _____

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE L. V. Sohler M.D.

Address East Street, Delmar, Delaware Date signed 2-5-46

RECEIVED
FEB 7 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 02022 933

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Since 7/13/44Hospital, institution, or street address where death occurred:
E. S. Tuberculosis SanatoriumHow long in hospital or institution? Since 7/13/44

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Howie Allen G.

4. Sex _____ 5. Color or race _____ 6.(a) Single, married, widowed, or divorced _____

Male White Single

6.(b) Name of husband or wife _____

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 22, 18808. AGE: Years 65 Months 8 Days 12 If less than one day _____ hrs. _____ min.9. Birthplace Towanda, Pennsylvania
(Town, county, and state)10. Usual occupation Bus Driver & Farmer

11. Industry or business _____

12. Name John T. Howie13. Birthplace Scotland14. Maiden name Ann Gibson15. Birthplace Scotland16. Informant self

Address _____

17. Burial Date thereat Feb 7-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Parson CemLocation Salisbury, Md18. Funeral Director Hallmayor & HesterAddress Salisbury Maryland19. 3/7/46 Harris E. Johnson
(Date rec'd by registrar) (Signature) Registrar

3. (b) Social Security Number

223-10-2266

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4, 1946 at _____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 13, 1944 to 2/4/46and that I last saw him alive on 2/4/46

Immediate cause of death _____ DURATION _____

Pulmonary Tuberculosis 2 years

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Injured at work? _____

23. SIGNATURE Paul Chen M.D. M. D. or other _____Address Snow Hill, Md. Date signed 2/4/46

RECEIVED

FEB 16 1946

BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 486

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....

5. Color or race.....

6. (a) Single, married, widowed, or divorced.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.).....

6. (c) If alive, give age..... years

8. AGE:

Years.....

Months.....

Days.....

If less than one day.....

hrs.....

min.....

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER
MOTHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial

(Burial, cremation, or removal. Which?).....

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by registrar.....

(Date rec'd by registrar)

Registrar.....

Registrar.....

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

19.....

at.....

19.....

at.....

M.....

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....

19.....

to.....

19.....

to.....

19.....

to.....

19.....

to.....

and that I last saw her alive on.....

19.....

to.....

19.....

to.....

19.....

to.....

19.....

to.....

19.....

Immediate cause of death.....

DURATION

Generalized Carcinomatosis

Due to Carcinoma of uterus.

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....

Date signed.....

RECEIVED

MAR 9 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Rockawalkin
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 52 Years

Hospital, institution, or street address where death occurred:

At Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town Rockawalkin
(If outside city or town limits, write RURAL and give nearest town)Street No. Salisbury Rural 2
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lillian G. Hughes

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.) Nov. 22, 1892

8. AGE:

Years

Months

Days

If less than one day

53212

hrs. min.

9. Birthplace

Wicomico, Co. Md
(Town, county, and state)

10. Usual occupation

At Home

11. Industry or business

FATHER
MOTHER12. Name Charles V. Hughes13. Birthplace Wicomico, Co. Md14. Maiden name Mary A. Fletcher15. Birthplace Wicomico, Co Md18. Informant V. V. HughesAddress Salisbury, Md.17. Burial Date thereof 2/5/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Parsons CemeteryLocation Salisbury, Md18. Funeral director The Hill & Johnson Co.Address Salisbury, Md19. 2/6/46 Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 3 19 46 at 4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 3 19 46 to Feb 3 19 46
and that I last saw him alive on Feb 3 19 46

Immediate cause of death

uraemia

DURATION

4 days

Due to

Chro nephritis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

James E. Johnson M. D. or other
Address Salisbury, Md Date signed Feb 4, 46

RECEIVED

FEB 16 1946

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Grance

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02025

Reg. Dist. No. 333

1. PLACE OF DEATH *Wicomico*
County *Salisbury*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
P.S. Hopt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State *md.* County *Wicomico*
City or town *Salisbury*
(If outside city or town limits, write RURAL and give nearest town)
Street No. *621 S. Winson*
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME *John William Insley*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Married*
6. (b) Name of husband or wife *Keturah Insley*
6. (c) If alive, give age _____ years
7. Birth date of deceased (mo., day, yr.) *Aug. 24 - 1862*
8. AGE: Years *83* Months *6* Days *3* If less than one day _____ hrs. _____ min.

9. Birthplace *Birah md.*
(Town, county, and state)

10. Usual occupation *Capt. of River & Bay*

11. Industry or business *Boats*

12. Name *Maac Insley*

13. Birthplace *Birah md.*

14. Maiden name *Dolly Insley*

15. Birthplace *Birah md.*

16. Informant *Mr. Lance Insley*

Address *621 S. Dr. St. Salisbury Md.*

17. Burial, cremation, or removal (Which?) *Buried* Date thereof *Mar. 27 1946*
(month) (day) (year)

Cemetery or crematory *Birah Church Cem.*

Location *Birah md.*

18. Funeral director *Wm. G. Walter R. Williams*

Address *Salisbury md.*

19. *3/27/46* Registrar *Wm. G. Walter R. Williams*

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 27* 19 *46* at *6:30 p* M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Feb. 1* 19 *46* to *Feb. 27* 19 *46*

and that I last saw him alive on *Feb. 27* 19 *46*

Immediate cause of death *Branchio-pneumonia* DURATION

Due to *Ch. Myocarditis*

Due to *Ch. Myocarditis*

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature *L. P. Grance M.D.*

Address *Salisbury md.* Date signed *3/1/46*

RECEIVED

MAR 12 1946

BUREAU U.S.

Dr. Rademacher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K7)

CERTIFICATE OF DEATH

02026

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Wicomico General Hospital

How long in hospital or institution?

3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County wicomico

City or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)

Street No. no
(If rural, give LOCATION) no 2

2.(a) If veteran, name war World war

3. (a) FULL NAME

Johnson - Elton

3. (b) Social Security Number

222-10-6411

4. Sex

male

5. Color or race

C

6.(a) Single, married, widowed, or divorced

Singles

6.(b) Name of husband or wife

none

7. Birth date of

deceased (mo., day, yr.)

about 1922

8. AGE:

Years

Months

Days

If less than one day

23

hrs.

min.

9. Birthplace

Belmar

(Town, county, and state)

10. Usual occupation

retired world war no 2

11. Industry or business

mechanic

FATHER

12. Name

Frank Johnson

MOTHER

13. Birthplace

Whaleyville

14. Maiden name

Florence Jones

15. Birthplace

Whaleyville

16. Informant

Mrs. Florence Johnson

Address

Belmar Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb 23, 1946
(month) (day) (year)

Cemetery or crematory

Union

Location

Belmar md

18. Funeral director

Jessie H. Stewart

Address

Salisbury md

19. 2/23, 1946

(Date recd by registrar)

1946

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 20

1946, at 1:48 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Ex am 10/15/45

Immediate cause of death

Pulmonary edema

DURATION

4 hrs

Due to

General peritonitis & shock

2 days

Due to

Stomach of jejunum & abdominal aorta

2 days

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Stomach of jejunum & abdominal aorta

Date of op. 2-17-46

Autopsy results

same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 2/17/46

Where did injury occur? Belmar (City or town) md (State)

Injured at home, farm, industry, public place (where?) public amusement place

Means of injury struck in side Injured at work? No

Dr. Rademacher was

Deputy Medical Examiner

23. SIGNATURE Dr. Rademacher M. D. or other

Address Salisbury md Date signed 2/20/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1946

BUREAU VS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (190)

CERTIFICATE OF DEATH

02027

Reg. Dist. No.

339

1. PLACE OF DEATH: Wisconsin
 County.....
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)

State..... New Jersey..... County.....
 City or town..... Atlantic City
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. was visiting brother- Enoch Jones
116 Catherine St., Salisbury, Md.
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Geo. P. Jones

3. (b) Social Security Number

4. Sex Male 5. Color or race Blk 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife.....

7. Birth date of not obtainable 6. (c) If alive, give age..... years
 deceased (mo., day, yr.)

8. AGE: Years 78 Months 5 Days - If less than one day
 hrs. - min. -

9. Birthplace..... Chambers, Md.
 (Town, county, and state)

10. Usual occupation..... Minister11. Industry or business..... Preaching12. Name..... Jacob Jones13. Birthplace..... Chambers, Md.14. Maiden name..... Anne Gale15. Birthplace..... Chambers, Md.16. Informant..... Enoch JonesAddress..... 116 Catherine St.17. (Burial, cremation, or removal, which?) Burial Date thereof..... Feb. 18 - 46
 (month) (day) (year)Cemetery or crematory..... Chambers M.E. ColoredLocation..... Chambers, Md.18. Funeral director..... H. G. G. G. G.Address..... Dr. Island, Md.19. Feb 18, 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb 15..... 19 46, at 7 A..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
7/12..... 19 46, to 7/15..... 19 46
 and that I last saw him/her alive on 7/14..... 19 46

Immediate cause of death..... Coronary Atherosclerosis

Due to..... Atherosclerosis

Due to..... Heart failure

Other conditions..... Heart failure of feet

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Chas. T. Foster

M. D. or other

Address..... Salisbury, Md.

Date signed..... 7/16/46

RECEIVED
MAR 12 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(B-2)

02028

CERTIFICATE OF DEATH

Reg. Dist. No. 11 336

1. PLACE OF DEATH:

County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: State Highway
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Delmar Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. State Highway
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Henry Claude Ker

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

(b) Name of husband or wife Gertrude Ker
(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) Dec 1-1860
8. AGE: Years 85 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Quantico, Maryland
(Town, county, and state)

10. Usual occupation Minister

11. Industry or business Baptist Church

12. Name Samuel Ker

13. Birthplace Worcester County, Md.

14. Maiden name Louisa Dapin

15. Birthplace Worcester County, Md.

16. Informant Gertrude Ker

Address Delmar, Delaware

17. Burial Date thereof Mar-2-1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Old School Baptist

Location Snow Hill, Ind.

18. Funeral director W. S. Marvel Co

Address Delmar, Delaware

19. March 1st 1946 Registrar Harry E. Hudson

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 1946 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1946 to Feb 27 1946 and that I last saw him alive on Feb 27 1946

Immediate cause of death Chronic coma DURATION 3 days

Due to Chronic nephritis 3 yrs

Due to Myocarditis 6 yrs

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury _____ Injured at work?

23. SIGNATURE H. L. Lymel M. D. or other _____

Address Delmar, Md Date signed Feb 27 1946

MARGIN RESERVED FOR BINDING

VS A15 T

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

RECEIVED

MAR 2 1946

BUREAU V

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. G. G. G. G.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 7320

02029

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County McComieCity or town Parsonsbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

at home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County McComieCity or town Parsonsbury
(If outside city or town limits, write RURAL and give nearest town)Street No. in village
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Floora Belle Layfield

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Daniel W. Layfield7. Birth date of deceased (mo., day, yr.) Aug. 19-18716. (c) If alive, give age 74 years

8. AGE:

Years 74Months 5Days 25

If less than one day

hrs. min.

9. Birthplace

P.O. Delmar Del.
(Town, county, and state)

10. Usual occupation

Home inf

11. Industry or business

at home

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18.

Funeral director

Address

19.

(Date rec'd by registrar)

19. 25/17/4619. 25/17/4619. 25/17/4619. 25/17/46

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14th 19 46 at 4:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1946 to Feb 1946
and that I last saw her alive on 12 Feb 19 46

Immediate cause of death

Ch. Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Cause of injury

Injured at work?

23. SIGNATURE

Lucas R. G. G. G. M. D. or otherAddress Salisbury, Md. Date signed 2-14-46

RECEIVED

MAR 12 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-1-E)

CERTIFICATE OF DEATH

02030

Reg. Dist. No. 11 336

1. PLACE OF DEATH:

County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 801 East Street
Stay in hospital or inst. (yrs., or mos., or days) 90 years
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Delmar Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 801 East
(If rural give LOCATION) _____
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Lavenia Elizabeth LeCates

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Wm. J. LeCates

6 (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) May 24, 1855

8. AGE: Years 90 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Wicomico County, Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

12. Name Peter Hastings

13. Birthplace Wicomico County, Md.

14. Maiden name Sallie Baker

15. Birthplace Wicomico County, Md.

16. Informant Mrs. Ernest Adkins

Address Delmar, Delaware

17. Burial Date thereof Feb. 10, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or place of interment LeCates

Location Delmar, Del. RFD

18. Funeral director W. S. Gandy Co.

Address Delmar, Del.

19. 2/10 1946 Harry E. Hudson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 1946, at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8 1946 to Feb 8 1946

and that I last saw her alive on Feb 7 1946

Immediate cause of death Comp. due to

general weakness & chronic

reflex

Due to Chronic reflex +

paralysis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. H. G. Nelson M. D. or other _____
Address Delmar, Del. Date signed 2/9/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 12 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

02031
★ Reg. Dist. No. 239

1. PLACE OF DEATH:
 County.....Wicomico
 City or town.....Salisbury
(If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....5 Years
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?.....5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State.....MD County.....Wicomico
 City or town.....Salisbury
(If outside city or town limits, write RURAL and give nearest town)
 Street No.....801 Church St.
(If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME
Mary E. Lynch

3. (b) Social Security Number

4. Sex.....Female 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Widowed
 6.(b) Name of husband or wife.....Charles Lynch
 6.(c) If alive, give age.....years
 7. Birth date of deceased (mo., day, yr.).....Dec. 19, 1876
 8. AGE: Years.....69 Months.....I Days.....23 If less than one day.....hrs.min.
 9. Birthplace.....Wicomico Co. Md
(town, county, and state)
 10. Usual occupation.....At Home
 11. Industry or business.....

FATHER
 12. Name.....John Godfrey
 13. Birthplace.....Worcester, Co. Md
MOTHER
 14. Maiden name.....Mary E. Kreitzer
 15. Birthplace.....Baltimore, Md
 16. Informant.....Mrs. Clarence Layfield
 Address.....Salisbury, Md
 17. Burial Date thereof.....2 / 13 / 46
(Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Parsons Cemetery
 Location.....Salisbury, Md
 18. Funeral director.....The Hill & Johnson Co
 Address.....Salisbury, Md
 19. 8 / 13 19 46
(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....Feb. 11, 1946.....58 P M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946 to Feb 1946 and that I last saw her alive on Feb 11, 1946
 Immediate cause of death.....Chronic Myocarditis
 Duration: not known
 Due to.....Arteriosclerosis Coronary
 Due to.....
 Other conditions.....Cerebral hemorrhage
(Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
 22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?.....
(City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?
 23. SIGNATURE.....L. P. Gramer M.D.
M. D. or other
 Address.....Salisbury, Md Date signed.....2-13-46

RECEIVED

MAR 12 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Fisher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County SalisburyCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 yearsHospital, institution, or street address where death occurred P.S. Hoyt

How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 506 E. Isabella St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Anna Marshall

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife David Marshall6. (c) If alive, give age 81 years7. Birth date of deceased (mo., day, yr.) Jan. 26 - 18728. AGE: Years 74 Months — Days 12 If less than one day
hrs. min.9. Birthplace Northampton England
(Town, county, and state)10. Usual occupation Housewife11. Industry or business at home12. Name John Brown13. Birthplace Rutledge England14. Maiden name —15. Birthplace England16. Informant M. David MarshallAddress 506 E. Isabella St. Salisbury Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 11 - 46
(month) (day) (year)Cemetery or crematory Wicomico Mem. ParkLocation Salisbury Md18. Funeral director Hollway, + Co. Walter R. HollwayAddress Salisbury Maryland19. 2/11/46 Registrar W. R. Hollway

(Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1946 130P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/7 1946 to 7/8 1946
and that I last saw him alive on 7/8 1946

Immediate cause of death

Cerebral Hemorrhage

DURATION

1 dayDue to arterio-sclerosisDue to senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Oliver Fisher

M. D. or other

Address Salisbury Md Date signed 2/10/46

RECEIVED

MAR 9 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-2

CERTIFICATE OF DEATH

 02033
 ★ Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? LifeHospital, institution, or street address where death occurred: 120 Cherry

How long in hospital or institution?

3. (a) FULL NAME

Neta Irene Mc Namara

3. (b) Social Security Number

4. Sex Female5. Color of race White6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Wm P. Mc Namara7. Birth date of deceased (mo., day, yr.) Nov. 28-18978. AGE: Years 48 Months 2 Days 19 It less than one day hrs. min.9. Birthplace Salisbury Md.
(Town, county, and state)10. Usual occupation Home wife11. Industry or business at home12. Name Franky Thomas13. Birthplace Wicomico Island, Md.14. Maiden name Alice M. Wilson15. Birthplace Mt. Vernon, Md.16. Informant Miss Elsie Mc NamaraAddress 120 Cherry St. Salisbury Md.17. Burial Burial Date thereof Feb. 20-46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematorium Parsons Cem.Location Salisbury Maryland18. Funeral director William G. Wright & SonAddress Salisbury Maryland19. 2/20/46 (Date rec'd by registrar)Registrar John E. JohnsonAddress Salisbury Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new-born infants give residence of mother)

State Md County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 120 Cherry St.
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 1946 at 46 1240p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 1946 to Feb 17 1946and that I last saw him/her alive on Feb 10 1946Immediate cause of death Cerebral HemorrhageDue to Hypertension & AtherosclerosisDue to Unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Injured at work?

Name of injury

23. SIGNATURE Dr. RademakerAddress Salisbury Md.Date signed 2/18/46

M. D. or other

RECEIVED

MAR 12 1946

BUREAU V.S.

RECEIVED

MAR 12 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 Years

Hospital, institution, or street address where death occurred:

703 Park Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. 703 Park Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Jessie B. Morre

3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FemaleWhiteMarriedB.(b) Name of husband or wife Robert D. Morre7. Birth date of deceased (mo., day, yr.) June 9 1888
B.(c) If alive, give age 58 years8. AGE: Years Months Days If less than one day
57 8 hrs. min.9. Birthplace Baltimore, Md
(town, county, and state)10. Usual occupation At Home

11. Industry or business

FATHER 12. Name Charles H. Bockmiller13. Birthplace Baltimore, MdMOTHER 14. Maiden name Jessie Banner15. Birthplace Baltimore, Md16. Informant Mr Robert D. MorreAddress Salisbury, Md17. Burial Date thereof 2 / 11 / 46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Wicomico Memorial ParkLocation Salisbury, Md18. Funeral director The Hill & Johnson Co.Address Salisbury, Md19. 2 / 11 / 46
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 9 19 4621. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 19 46 to Feb 9 19 46and that I last saw him alive on Feb 9 19 46

Immediate cause of death

DURATION

Generalized CorianderitisDue to Carcinoma of Breast

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. J. H. Hanson, M.D.

M. D. or other

Address Salisbury, Md Date signed 2/11/46

RECEIVED

MAR 9 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

CERTIFICATE OF DEATH

02035



Reg. Dist. No. 933

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Penninsula General Hospital

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Del County Sussex

City or town Seaford
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Marion H. Nelson

3. (b) Social Security Number

4. Sex

male

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ellen S. Nelson

6. (c) If alive, give age 78 years

7. Birth date of

deceased (mo., day, yr.) May 20, 1868

8. AGE:

Years 77

Months 9

Days 5

If less than one day

hrs. _____ min. _____

9. Birthplace

Delmar County, Del.

(Town, county, and state)

10. Usual occupation

Store Catter

11. Industry or business

Marshall works

FATHER

12. Name

Charles Nelson

13. Birthplace

Delmar

MOTHER

14. Maiden name

Martha Frankens

15. Birthplace

Delmar

16. Informant

R B Seaford Del.

Address

Removal Date thereof May 1-46

(Burial, cremation, or removal. Which?)

Cemetery or crematory

9004 Seaford Del.

Location

Seaford Delaware

16. Funeral director

H E Hardesty & Son

Address

Burgessville Del

19. 3/1 1946

(Date read by Registrar)

Registrar

Address

23. SIGNATURE

Bachman R Gray

M. D. or other

2/26/46

Date signed

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 25 1946 at 49 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 16 1946 to Feb. 25 1946

and that I last saw him alive on Feb. 24 1946

Immediate cause of death

Pneumonia

DURATION

Due to

Cerebral apoplexy &

Hemiplegia

Due to

Pruritic eczema & V-dysent

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Manner of injury _____ Injured at work? _____

23. SIGNATURE Bachman R Gray

M. D. or other

2/26/46

Date signed

RECEIVED

MAR 12 1946

BUREAU OF

Dr. Maturin

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
County..... Allen Md. (If outside city or town limits, write RURAL and give nearest town)		State..... Md. County..... Harford	
City or town..... Allen Md. P.O. #1 (If outside city or town limits, write RURAL and give nearest town)		City or town..... Box 133 (If rural, give LOCATION)	
How long in above place of death? Hospital, institution, or street address where death occurred Allen Md. P.O. #1		2(a) If veteran, name war.....	
How long in hospital or institution?.....			
3. (a) FULL NAME Martha Fitzgerald O'Brien		3. (b) Social Security Number	
4. Sex F	5. Color or race W.	6. (a) Single, married, widowed, or divorced Widowed	
6. (b) Name of husband or wife John O'Brien		6. (c) If alive, give age years	
7. Birth date of deceased (mo., day, year) Feb. 15 - 1863			
8. AGE Years 82	Months 11	Days 20	If less than one day hrs. min.
9. Birthplace..... Huntland Md. (Town, county, and state)			
10. Usual occupation..... At Home			
11. Industry or business			
12. Name..... Jones			
13. Birthplace..... Huntland Md.			
14. Maiden name..... Hattie Turner			
15. Birthplace..... Huntland Md.			
16. Informant Mrs. Edith McEwen			
Address Box 133 Allen Md. P.O. #1			
17. Burial Date thereof Feb. 7 - 46 (Burial, cremation, or removal, where?) (month) (day) (year)			
Cemetery or crematory..... Allen Cem.			
Location..... Allen Maryland			
18. Funeral director Hoffman + Co. Walter R. Hoffman			
Address Salisbury Md.			
19. 2/1/46 Registrar			
20. DATE OF DEATH Feb. 5th 1946 at 3:20 PM			
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 1946 to Feb 4 1946 and that I last saw him alive on Feb 4 1946			
Immediate cause of death..... Coronary			
Due to..... Coronary thrombosis			
Due to..... arteriosclerosis			
Other conditions..... Infarction			
Major findings of operations.....			
Autopsy results.....			
PHYSICIAN: Please underline the cause to which death should be charged statistically.			
22. VIOLENCE: If death was due to external causes, fill in the following:			
Accident, suicide, or homicide..... Date of.....			
Where did injury occur?..... (City or town) (County) (State)			
Injured at home, farm, industry, public place (where?).....			
Means of injury..... Injured at work?			
23. SIGNATURE Frank Waters MD			
Address..... Prince Georges Anne Arundel M. D. or other			
Date signed 2/1/46			

RECEIVED
FEB 16 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore ④

CERTIFICATE OF DEATH

Reg. Dist. No. 335

1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex

5. Color of race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or other Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19. 1946

Walter H. Mann

Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH

Feb 22

1946

at

20

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 16

1946

to

Feb 21

1946

and that I last saw him alive on

Feb 21

1946

Immediate cause of death

Diabetes mellitus
Chronic Nephritis

DURATION

10 years

6 years

Due to

Due to

Other conditions

Cerebral

5 days

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Kuhlman

M. D.

Address

Sharptown Md

Date signed

2/23/46

RECEIVED
FEB 26 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age of deceased is shown on

Evidence for change of age of deceased is shown on

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 337

FILM No. 101 MAY - 2 1946

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, institution, or street address where death occurred:

Nanticoke

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County Wicomico

City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Ware Franklin Robertson

3. (b) Social Security Number

4. Sex male

5. Color or race white

6. (a) Single, married, widowed, or divorced divorced

8. (b) Name of husband or wife Mary White Marshall

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov. 22 1877

8. AGE: Years 68 Months 9 Days 4 If less than one day _____ hrs. _____ min.

9. Birthplace Accomac, Va.
(Town, county, and state)

10. Usual occupation Sailor

11. Industry or business _____

12. Name John Robert Robertson

13. Birthplace Wicomico Co - Md.

14. Maiden name Rebecca Elizabeth Willing

15. Birthplace Nanticoke, Md.

16. Informant Miss Ora Willing

Address Nanticoke, Md.

17. Burial Date thereof 3/1/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Willing cemetery

Location Nanticoke, Md.

18. Funeral director Rebecca Willing

Address Baltimore Md.

19. Mar 1 19 46 Registrar R. M. Hallford

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 27 19 46 at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 19 46 to Feb 26 19 46

and that I last saw him alive on Feb 26 19 46

Immediate cause of death Crown Arteriosclerosis

Other conditions arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Antopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work?

23. SIGNATURE William E. Enrich

Address Helroy - Md.

Date signed Feb 28-46

REC
APR 6
BUREAU

RECEIVED
APR 6 1946
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 399

1. PLACE OF DEATH:

County SalisburyCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death

Hospital, institution, or street address where death occurred:

R.D. #3 (Delmar Road)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County McComieCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #3 (Delmar Road)

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lucy B. Ruark

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Samuel Ruark

7. Birth date of

deceased (mo., day, yr.)

Oct. 15 - 18698. (c) If alive, give age 72 years

8. AGE:

Years 76 Months 3 Days 21 If less than one day

9. Birthplace

Worcester Co. Md.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

General Manager & Farmer

12. Name

John J. Ruark

13. Birthplace

Worcester Co. Md.

14. Maiden name

Nancy Ruark

15. Birthplace

Worcester Co. Md.

16. Informant

Mr. Elmer W. Ruark

Address

R.D. #3 (Delmar Rd.) Salisbury Md.

17. Burial

Parsons Cem.

Cemetery or crematorium

Salisbury Maryland

Location

Holloman & Co. Walter R. Holloman

18. Funeral director

Salisbury Maryland

Address

3/8/46

19. (Date rec'd by registrar)

20. Date of death

Feb. 6 46

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 2 1946 to Feb 6 1946and that I last saw him alive on Feb. 4 1946

Immediate cause of death

Coronary occlusionDue to arteriosclerosis

Due to

Other conditions Upper respiratory infection

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

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FEB 16 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1228P

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 1/2 hrs

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 2 1/2 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WorcesterCity or town Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)Street No. ✓
(If rural, give LOCATION) ✓2.(a) If veteran, name war ✓

3.(a) FULL NAME

Powell Mr. Samuel

3.(b) Social Security Number

✓

4. Sex

Male

5. Color or race

W

6.(a) Single, married, widowed, or divorced

married8.(b) Name of husband or wife Rene M. Powell7. Birth date of deceased (mo., day, yr.) May 16 - 1868B.(c) If alive, give age 75 years

8. AGE:

Years

Months

Days

It less than one day

77825hrs.min.

9. Birthplace

Pocomoke Worcester Md.

(Town, county, and state)

10. Usual occupation

Shrimping

11. Industry or business

Alexander Powell

12. Name

FATHER

13. Birthplace

Maryland.

14. Maiden name

Sarah Ellen Puff

15. Birthplace

Ohio

16. Informant

Elick Powell

Address

Snow Hill Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb 14, 1946
(month) (day) (year)

Cemetery or crematory

Salmon M. E. Cemetery

Location

Pocomoke Md.

18. Funeral director

Margarette E. Watson

Address

Pocomoke Md.

19.

Date rec'd by registrar 2/14/46Registrar Harriet E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 - 1946 at 2 1/2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 10 - 1946 to Feb 11 - 1946and that I last saw him alive on Feb 11 - 1946

Immediate cause of death

Intestinal obstructionDue to obstruction of smallDue to adhesions of smallDue to not due to cancer

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Philip A. Insley M.D.
M. D. or otherAddress Salisbury Md. Date signed 2-11-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County..... Wiconico
 City or town..... Salisbury R. D. 4
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?..... 10 Weeks
 Hospital, institution, or street address where death occurred:
Ocean City Road
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Fla County..... Pinellas
 City or town..... St. Petersburg Fla.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No..... 3495 16th Ave South
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Louise Margaret Spence

3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married
 6.(b) Name of husband or wife..... Thomas Brand Spence
 6.(c) If alive, give age..... 51 years
 7. Birth date of deceased (mo., day, yr.)..... April, 6, 1895
 8. AGE: Years..... 50 Months..... 10 Days..... 15 If less than one day..... hrs. min.

9. Birthplace..... Bayonne, N. J.
 (Town, county, and state)
 10. Usual occupation..... At Home
 11. Industry or business.....

12. Name..... George H. Kramer
 13. Birthplace..... Long Island, N. Y.
 14. Maiden name..... Cecil B. Kern
 15. Birthplace..... States Island N. Y.

16. Informant..... Mr. Thomas B. Spence
 Address..... Salisbury, Md R.D. 4
 17. Burial Date thereof..... 2/22/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory..... Parsons Cemetery
 Location..... Salisbury, Md

18. Funeral director..... The Hill & Johnson Co
 Address..... Salisbury, Md

19. 2/22/46 19. 46 Harris & Johnson
 (Date rec'd by registrar) (month) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Feb. 19 19. 46 at 353P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Jan. 25 19. 46 to Feb. 19 19. 46
 and that I last saw him alive on Feb. 18 19. 46

Immediate cause of death..... Generalized Carcinomatosis 1 1/2 yrs
 DURATION

Due to..... Cancer of Breast (Primary)

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Ca Breast

Date of op.....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... H. J. Hanson, M.D.

M. D. or other

Address..... Salisbury, Md Date signed..... 2-22-46

RECEIVED

MAR 12 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1700

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Near Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County WicomicoCity or town Parsonsburg Rural 2
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Paul S. Tilghman

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Bertie Tilghman6. (c) If alive, give age 54 years

7. Birth date of

deceased (mo., day, yr.)

March 23, 1884

8. AGE:

Years

Months

Days

If less than one day

611010

.....hrs.

.....min.

9. Birthplace Parsonsburg, Wicomico Co. Md10. Usual occupation Farmer

11. Industry or business

FATHER
MOTHER12. Name Sylvester Tilghman13. Birthplace Wicomico, Co. Md14. Maiden name Rose Leach15. Birthplace Delaware16. Informant Mrs Paul S. TilghmanAddress Parsonsburg, Md17. Bural Date thereof 2/3/46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Methodist CemeteryLocation Parsonsburg, Md16. Funeral director The Hill & Johnson Co.Address Salisbury, Md19. 2/3/46 19 46
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 2 19 46 at 12:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 2 19 46, to FEB 2 19 46
and that I last saw h..... alive on 19.....

Immediate cause of death

Fractured Skull

DURATION

Due to

Due to

Other conditions

multiple Compound fractures
(Include pregnancy within 3 months of death)

Major findings of operations

none Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

Parsonsburg Wicomico Md
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Auto accident Injured at work? NO

23. SIGNATURE

Skinner Hanson, M.D.
M. D. or other
Address Salisbury, Md Date signed 2/3/46

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FEB 16 1946

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:

County WicomicoCity or town Delmar - Rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? life

Hospital, institution, or street address where death occurred:

Delmar - Salisbury Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Delmar - Delaware - Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. Delmar Salisbury Road
(If rural, give LOCATION)

2.(a) If veteran, name War

3. (a) FULL NAME

Olevia J. Walker

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife James Walker7. Birth date of deceased (mo., day, yr.) February 6, 1870
8. (c) If alive, give age 66 years8. AGE: Years 76 Months 0 Days 1 It less than one day
.....hrs.min.9. Birthplace Sharptown Maryland - RFD.
(Town, county, and state)10. Usual occupation Housework11. Industry or business None12. Name George W. Brown13. Birthplace Wicomico County, Maryland14. Maiden name Mary E. Hubbard15. Birthplace Wicomico County, Maryland16. Informant James WalkerAddress Delmar, Delaware, RFD. #317. Burial Date thereof February 11, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory San Domingo CemeteryLocation Near Sharptown, Maryland18. Funeral director J. J. Frampton and SonAddress Federalburg, Maryland19. 2/9/46 Registrar W. H. Johnson

(Date rec'd by Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 7, 1946 at 3:15 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
December 1945 to Febr. 7, 1946and that I last saw him alive on Febr. 6, 1946Immediate cause of death Paraplegia right DURATION 10 daysDue to Embolism cereb. artery left 10 daysDue to Complete heart block 6 weekscoronary disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. V. Fohler M.D.Address Delmar, Delaware Date signed 2-7-46

RECEIVED

FEB 16 1945

BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:

County.....Wicomico
 City or town.....Salisbury
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?.....3 Days
 Hospital, institution, or street address where death occurred:
Peninsula General Hospital
 How long in hospital or institution?.....3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Md County.....Wicomico
 City or town.....Salisbury R.D.3
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

3. (b) Social Security Number

4. Sex.....Male 5. Color or race.....White 6.(a) Single, married, widowed, or divorced.....Single
 8.(b) Name of husband or wife.....
 7. Birth date of deceased (mo., day, yr.).....Feb. 18, 1946 8.(c) If alive, give age..... years
 8. AGE: Years..... Months..... Days..... If less than one day..... hrs. min.
3

9. Birthplace.....Salisbury, Wicomico Co., Md
 (Town, county, and state)
 10. Usual occupation.....None
 11. Industry or business.....

12. Name.....Byard Walston
 13. Birthplace.....Wicomico, Co Md
 14. Maiden name.....Ruth Marvel
 15. Birthplace.....Wicomico, Co. Md

18. Informant.....Mr Byard Walston
 Address.....Salisbury, Md R.D.3
 17. Burial..... Date thereof.....2/22/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory.....Parson Cemetery
 Location.....Salisbury, Md

18. Funeral director.....The Hill & Johnson Co.
 Address.....Salisbury, Md

19. 2/22/46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH.....2-21 19..46 at 5:12 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
2-18 19..46 to 2-21 19..46
 and that I last saw h..... alive on..... 19..46

Immediate cause of death.....
Status Lymphicus
 Due to.....Lymphatic
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
 Autopsy results.....Status Lymphicus Lymphatic
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?

23. SIGNATURE.....Philip A. Smith M. D. or other
 Address.....Salisbury, Md Date signed.....2-21-46

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MAR 12 1946
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County WicomicoCity or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County WicomicoCity or town Salisbury md
(If outside city or town limits, write RURAL and give nearest town)Street No. 508 Wardell
(If rural, give LOCATION)2(a) If veteran, name war no

3. (a) FULL NAME

Wardell Charles

3. (b) Social Security Number

no

4. Sex

M

5. Color or race

C

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

no6. (c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.)

mar 26 1938

8. AGE:

Years

Months

Days

If less than one day

71018

hrs.

min.

9. Birthplace

Salisbury md
(Town, county, and state)

10. Usual occupation

School no

11. Industry or business

FATHER

12. Name

Charles Wardell

13. Birthplace

Baltimore md

MOTHER

14. Maiden name

Bessie Lawrence

15. Birthplace

Whitehaven Ind

16. Informant

Mrs. Bessie Wardell

Address

Salisbury md

17.

Burial
(Burial, cremation, or removal. Which?)

Date thereof

Feb 20 - 1946
(month) (day) (year)

Cemetery or crematory

Family

Location

Whitehaven Ind

18. Funeral director

James H. Stewart

Address

Salisbury md

19.

2/20/46

(Date read by registrar)

Charles Wardell

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 - 1 1946 at 2:08 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

16 Feb. 1946 to 17 Feb. 1946and that I last saw him alive on 19

Immediate cause of death

Bilateral lobar pneumonia

DURATION

2 days

Due to

Due to

Other conditions

Pleuritis2 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles Wardell

M. D. or other

Address

231 1/2 Camden AveDate signed 19 Feb 46

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MAR 12 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico
 City or town Bridgewater
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 13 months
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico
 City or town Bridgewater
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I

3. (a) FULL NAME

Edward E. Wheeler

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Emily Wheeler7. Birth date of deceased (mo., day, yr.) June 3, 1898 6. (c) If alive, give age 38 years8. AGE: Years 47 Months 8 Days 8 If less than one day _____ hrs. _____ min.9. Birthplace Charlotte Court House, Va.
(Town, county, and state)10. Usual occupation Retired Dentist

11. Industry or business

12. Name Spry Wheeler13. Birthplace Ohio14. Maiden name Ida M. Colgate15. Birthplace about know16. Informant Emily WheelerAddress Bridgewater, Md.17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Feb. 14, 1946
(month) (day) (year)Cemetery or crematory Bridgewater cemeteryLocation Bridgewater, Md.18. Funeral director E. J. MessickAddress Bridgewater, Md.19. Feb. 18 19 46 R. Woodford Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 19 46 at 10:45 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10:45 AM to 11:00 AM and that I last saw him alive on Feb. 11, 1946Immediate cause of death Coronary Thrombosis

Due to _____

Due to _____

Other conditions Chronic myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Salisbury Md. Garrison M. D. or other _____Address Salisbury Md. Date signed 2/13/46DURATION
1 yr
1 yr
death

REC'D
FEB 25 1946
BUREAU 7 B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

CERTIFICATE OF DEATH

Reg. Dist. No. 112-933

1. PLACE OF DEATH:

County Wicomico
City or town Salisbury Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
PENINSULA General Hospital
How long in hospital or institution? 18 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State MD County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)
2.(a) If veteran, name war World War #1

3. (a) FULL NAME

Wright, Hasey Knight
4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced Married

3. (b) Social Security Number

261-16-2917

6. (b) Name of husband or wife Paul Wright (wife)

7. Birth date of deceased (mo., day, yr.) Birth date of Deceased May 24, 1888 6. (c) If alive, give age _____ years

8. AGE: Year 58 Months 9 Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Tampa, Fla.
(Town, county, and state)

10. Usual occupation General Labor

11. Industry or business Southern States Inc.

12. Name Paul Johnson

13. Birthplace Tampa, Fla.

14. Maiden name ?

15. Birthplace ?

16. Informant Paul Johnson

Address 4102 L St. N. Salisbury Md.

17. Funeral Date thereof 7-25-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Wentworth Md.

Location near Eastern Shore

18. Funeral director B. Messer

Address Baltimore Md.

19. 8/21/46 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 17 Feb 19 46 at 5:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Feb 19 46 to 17 Feb 19 46
and that I last saw him alive on 17 Feb 19 46

Immediate cause of death Bronchopneumonia

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE W. E. Levitt, M.D. M. D. or other _____

Address Peninsula General Hosp. Date signed 17 Feb 46

MARGIN RESERVED FOR BINDING

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VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 12 1946

BUREAU V S